

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041528

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10992

## 1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR  
TOWN St. Louis Mo.

Length of stay in 1b

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo.

b. COUNTY

admission)

c. CITY  
OR  
TOWN

St. Louis

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR  
INSTITUTION

St. Louis City Hosp. #1

Inside Limits

Yes ☒ No ☐

d. STREET (If outside, give location)

ADDRESS

4916 A St Louis Ave

Reside on Form

Yes ☐ No ☒

## 3. NAME OF DECEASED

(Type or print)

First

Ella

Middle

Last

Haney

4. DATE  
OF  
DEATH

Month/3/63

Day

Year

## 5. SEX

Female

## 6. COLOR OR RACE

Negro

## 7. Married ☐ Never Married ☐

Widowed ☒ Divorced ☐

## 8. DATE OF BIRTH

9/17/1887

## 9. AGE (last birthday)

76

## IF UNDER 1 YEAR IF UNDER 24 HR

Months Days Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

## 10b. KIND OF BUSINESS OR INDUSTRY

None

## 11. BIRTHPLACE (City and state or country)

Pine Bluff Ark

## 12. CITIZEN OF WHAT COUNTRY

U. S. A

## 13a. FATHER'S NAME

Nelson Scales

## 13b. MOTHER'S MAIDEN NAME

Mary Pointer

## 14. NAME OF HUSBAND OR WIFE

Deceased

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES

(Yes, no, or unknown) (If yes, give war or date)

No No

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

Address

Floyd Brown 4916 St. Louis Ave

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

### PART I. DEATH WAS CAUSED BY:

#### IMMEDIATE CAUSE (a)

CONGESTIVE HEART FAILURE

#### DUE TO (b)

LENTIC AORTITIS

#### DUE TO (c)

023X

### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

SUBACUTE CYSTITIS

### PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

## 19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

## 20a. ACCIDENT

☐

## SUICIDE

☐

## HOMICIDE

☐

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

## 20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

## 20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

## 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

## 20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 9/22/63 to 11/3/63 and last saw her alive on 11/3/63

Death occurred at 11:50PM

on the date stated above, and to the best of my knowledge, from the causes stated.

## 22a. SIGNATURE

(Degree or title)

Donald K. Back, M.D.

## 22b. ADDRESS

1515 Lafayette Ave

## 22c. DATE SIGNED

11/3/63

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

## 23b. DATE

Nov 8, 1963

## 23c. NAME OF CEMETERY OR CREMATORY

Washington Cemetery

## 23d. LOCATION (City, town, or county)

St. Louis County

Mo.

## 24. FUNERAL DIRECTOR

ADDRESS

1221 N. Grand Blvd.

## 25. DATE RECD. BY LOCAL REG.

NOV 6 1963

## 26. REGISTRAR'S SIGNATURE

Donald Smith, M.D.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Oliver E. Crumble*

Licensed Embalmer No. 5185

P. O. Address 1221 N. Grand Blvd.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.